		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011643

Facility Name: SUNSET HOME

Address: 418 WASHINGTON (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: 217-223-2636 **Fax #** 217-223-9867

IDPA ID Number: 370661224-001

Date of Initial License for Current Owners: NOT AVAILABLE

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: RUTH STOWE **Telephone Number:** 217-223-2636 EXT 311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/03 to 09/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 12/22/04 (Date)
(Type or Print Name) JUDY KIRLIN
(Title) CEO/ADMINISTRATOR

Paid Preparer

(Signed) 12/22/04 (Date)
(Print Name and Title) TIMOTHY WIEWEL, PROPRIETOR
(Firm Name & Address) TIMOTHY J WIEWEL CPA, PO BOX 1028 QUINCY IL 62306
(Telephone) 217-223-2245 Fax # 217-223-7580

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 05/27/04

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,954	1
2		Skilled Pediatric (SNF/PED)			2
3	148	Intermediate (ICF)	152	54,676	3
4		Intermediate/DD			4
5	81	Sheltered Care (SC)	31	23,296	5
6		ICF/DD 16 or Less			6
7	248	TOTALS	202	84,926	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	295	6	4,107	4,408	8
9	SNF/PED					9
10	ICF	21,258	30,810		52,068	10
11	ICF/DD					11
12	SC	2,203	8,201		10,404	12
13	DD 16 OR LESS					13
14	TOTALS	23,756	39,017	4,107	66,880	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.75%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
INDIVIDUAL LIVING UNITS, SENIOR APARTMENTS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified and days of care provided

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	560,616	38,534	9,660	608,810		608,810		608,810			1
2	Food Purchase		251,915		251,915		251,915		251,915			2
3	Housekeeping	254,013	45,586		299,599		299,599		299,599			3
4	Laundry	45,911	2,989	137,441	186,341		186,341		186,341			4
5	Heat and Other Utilities			322,100	322,100		322,100		322,100			5
6	Maintenance	183,321	43,112	79,415	305,848	(1,287)	304,561	12,431	316,992			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,043,861	382,136	548,616	1,974,613	(1,287)	1,973,326	12,431	1,985,757			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,780,867	116,377	26,968	3,924,212		3,924,212		3,924,212			10
10a	Therapy	13,901	3,406	421,703	439,010		439,010		439,010			10a
11	Activities	132,825	5,999	6,175	144,999		144,999		144,999			11
12	Social Services	100,122	16	2,326	102,464		102,464		102,464			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,027,715	125,798	457,172	4,610,685		4,610,685		4,610,685			16
	C. General Administration											
17	Administrative	81,263			81,263		81,263		81,263			17
18	Directors Fees											18
19	Professional Services			45,281	45,281		45,281	(8,392)	36,889			19
20	Dues, Fees, Subscriptions & Promotions			45,735	45,735		45,735	(18,559)	27,176			20
21	Clerical & General Office Expenses	274,818	10,773	113,333	398,924		398,924		398,924			21
22	Employee Benefits & Payroll Taxes			949,966	949,966	(5,300)	944,666		944,666			22
23	Inservice Training & Education			4,323	4,323		4,323		4,323			23
24	Travel and Seminar			10,899	10,899		10,899	(2,494)	8,405			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			147,678	147,678		147,678		147,678			26
27	Other (specify):* BAD DEBT			8,433	8,433		8,433	(8,433)				27
28	**TOTAL General Administration**	356,081	10,773	1,325,648	1,692,502	(5,300)	1,687,202	(37,878)	1,649,324			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,427,657	518,707	2,331,436	8,277,800	(6,587)	8,271,213	(25,447)	8,245,766			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SUNSET HOME #0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			468,555	468,555	(108,821)	359,734		359,734			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,867	134,867	(134,103)	764	(764)				32
33	Real Estate Taxes					1,287	1,287	(713)	574			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			603,422	603,422	(241,637)	361,785	(1,477)	360,308			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,481		72,481		72,481		72,481			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			92,446	92,446		92,446		92,446			42
43	Other (specify):*			399,619	399,619	248,224	647,843	(647,843)				43
44	**TOTAL Special Cost Centers**		72,481	492,065	564,546	248,224	812,770	(647,843)	164,927			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,427,657	591,188	3,426,923	9,445,768		9,445,768	(674,767)	8,771,001			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	12,431	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(764)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(22,500)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,392)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,433)	27		24
25	Fund Raising, Advertising and Promotional	(59,328)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE 5-A	(587,781)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (674,767)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (674,767)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SUNSET HOME

ID# 0011643

Report Period Beginning: 10/1/03

Ending: 09/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	OUT OF STATE TRANSPORTATION SEMINAR	(2,494)	24	2
3	REAL ESTATE TAXES	(713)	33	3
4	VILLA APRTMENTS	(507,811)	43	4
5	SUNSET APARTMENTS	(80,704)	43	5
6	IDPA PREPAID LICENSE FEE PAID 2003 FOR 2004	3,480	20	6
7	PREPAID WORKERS BACKGROUND CHECKS	461	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(587,781)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/1/03 **Ending:** 09/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	12,431	0	0	0	0	0	0	0	0	0	0	12,431	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	12,431	0	0	0	0	0	0	0	0	0	0	12,431	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,392)	0	0	0	0	0	0	0	0	0	0	(8,392)	19
20	Fees, Subscriptions & Promotions	(18,559)	0	0	0	0	0	0	0	0	0	0	(18,559)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,494)	0	0	0	0	0	0	0	0	0	0	(2,494)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(8,433)	0	0	0	0	0	0	0	0	0	0	(8,433)	27
28	**TOTAL General Administration**	(37,878)	0	0	0	0	0	0	0	0	0	0	(37,878)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,447)	0	0	0	0	0	0	0	0	0	0	(25,447)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SUNSET HOME **#** 0011643 **Report Period Beginning:** 10/1/03 **Ending:** 09/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(764)	0	0	0	0	0	0	0	0	0	0	(764)	32
33	Real Estate Taxes	(713)	0	0	0	0	0	0	0	0	0	0	(713)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,477)	0	0	0	0	0	0	0	0	0	0	(1,477)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(647,843)	0	0	0	0	0	0	0	0	0	0	(647,843)	43
44	**TOTAL Special Cost Centers**	(647,843)	0	0	0	0	0	0	0	0	0	0	(647,843)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(674,767)	0	0	0	0	0	0	0	0	0	0	(674,767)	45

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	GIFT ANNUITIES		X	NONE							764	10
11	MERCANTILE		X	PURCHASE APART LOC				268,306	12/21/2007	0.0400	17,000	11
12	MERCANTILE		X	PURCHASE APARTMENTS			2,000,000				25,000	12
13			X	APARTMENTS PERM LOAN			2,850,000	2,850,000	12/19/2028	0.0450	92,103	13
14	TOTAL Non-Facility Related						$ 4,850,000	$ 3,118,306			$ 134,867	14
15	TOTALS (line 9+line14)						$ 4,850,000	$ 3,118,306			$ 134,867	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 574	2
3. Under or (over) accrual (line 2 minus line 1).	$ 574	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 574	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001	552	10
2002	567	11
2003	574	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNSET HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT RUTH STOWE

TELEPHONE 217-223-2636 EXT 311 FAX #: 217-223-9867

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-2-0972-000-00	812 S 4TH	$ 295.78	$ 295.78
2.	23-2-0973-000-00	810 S 4TH	$ 38.10	$ 38.10
3.	23-2-0917-000-00	700 S 5TH	$ 80.36	$ 80.36
4.	23-2-0926-000-00	701 S 4TH	$ 159.32	$ 159.32
5.	23-2-0971-000-00	820 S 4TH	$ 713.46	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,287.02	$ 573.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 144,818 B. General Construction Type: Exterior BRICK Frame STEEL-FIREPROOF Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

VILLA APARTMENTS 16-2 BEDROOM UNITS 16,000 SQ FT

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	199,487		$ 102,419	1
2	PARKING LOT ADDITIONAL	15,000	1996-97	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1958	1958	$ 354,000	$ 7,080	50	$ 7,080	$	$ 329,220	4
5	71		1971	1971	1,218,562	24,371	50	24,371		804,224	5
6	49		1972	1972	472,577	9,452	50	9,452		309,544	6
7	5		1987	1987	68,497	3,425	20	3,425		58,509	7
8	43		2001	2001	2,500,281	83,343	30	83,343		250,028	8
	Improvement Type**										
9	BUILDINGS & IMPROVEMENTS			1958	12,000		10			12,000	9
10	BUILDINGS & IMPROVEMENTS			1972	51,124	1,023	50	1,023		32,726	10
11	BUILDINGS & IMPROVEMENTS			1977	14,179		20			14,179	11
12	BUILDINGS & IMPROVEMENTS			1978	442,103	8,842	50	8,842		234,429	12
13	BUILDINGS & IMPROVEMENTS			1979	13,639	273	50	273		6,959	13
14	BUILDINGS & IMPROVEMENTS			1980	771		20			771	14
15	BUILDINGS & IMPROVEMENTS			1981	3,742		10			3,742	15
16	BUILDINGS & IMPROVEMENTS			1982	13,900		10			13,900	16
17	BUILDINGS & IMPROVEMENTS			1983	14,951		20			14,951	17
18	BUILDINGS & IMPROVEMENTS			1985	272,013	6,800	40	6,800		131,350	18
19	BUILDINGS & IMPROVEMENTS			1987	321,886	14,347	10-20	14,347		287,188	19
20	BUILDINGS & IMPROVEMENTS			1988	36,315	239	10-20	239		35,502	20
21	BUILDINGS & IMPROVEMENTS			1989	99,114	4,173	10-20	4,173		82,744	21
22	BUILDINGS & IMPROVEMENTS			1990	36,949	1,847	20	1,847		26,091	22
23	BUILDINGS & IMPROVEMENTS			1992	11,222	156	10-20	156		10,022	23
24	BUILDINGS & IMPROVEMENTS			1993	33,274	1,241	5-10-20	1,241		22,270	24
25	BUILDINGS & IMPROVEMENTS			1994	9,466	382	5-20	382		5,838	25
26	BUILDINGS & IMPROVEMENTS			1995	99,649	6,990	5-10-15	6,990		69,909	26
27	BUILDINGS & IMPROVEMENTS			1996	33,788	1,256	5-20	1,256		18,905	27
28	BUILDINGS & IMPROVEMENTS			1997	401,000	19,468	5-10-20	19,468		162,640	28
29	BUILDINGS & IMPROVEMENTS			1998	107,004	5,298	5-10-20	5,298		37,597	29
30	BUILDINGS & IMPROVEMENTS			1999	3,684	368	10	368		2,026	30
31	BUILDINGS & IMPROVEMENTS			2000	35,444	1,772	20	1,772		6,729	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WNDOW BLINDS VALANCES 2 NORTH	2001	$ 4,445	$ 445	10	$ 445	$	$ 1,556	37
38	SHADES FOR SCU CORNER WINDOWS	2001	1,282	128	10	128		449	38
39	GATES SCU	2001	1,685	112	15	112		393	39
40	NURSES STATION 2 NORTH	2001	1,550	78	20	78		271	40
41	AUTO DOOR SMOKE ROOM 1SW RESIDENTS	2001	2,596	260	10	260		909	41
42	NURSES FRONT DESK	2001	975	49	20	49		122	42
43	NW FRONT DOOR LOBBY AUTOMATIC WEST	2001	2,173	217	10	217		543	43
44	REROOF BOILER & CHILLER AREA	2001	9,415	942	10	942		2,354	44
45	COURT YARD GARDEN DOOR & ELECTRIC STRIKE	2002	3,422	342	10	342		856	45
46	HOLLOW METAL DOORS	2002	4,573	457	10	457		1,143	46
47	REROOF CHAPEL	2002	3,600	360	10	360		900	47
48	REROOF KITCHEN & CAFETERIA	2002	18,300	1,830	10	1,830		4,575	48
49	KITCHEN FREEZER DEFROSTER TIMER	2002	1,115	112	10	112		279	49
50	PLANK FLOOR 2ND FLOOR	2002	4,487	449	10	449		1,122	50
51	REMODEL BEAUTY SHOP	2002	4,722	472	10	472		1,181	51
52	CONVERT 366 & 368 TO 2 PRIVATE ROOMS	2002	8,771	439	20	439		658	52
53	3 DOORS-REHAB OFFICE, CARE PLAN ROOM EXIT 33	2004	1,628	81	10	81		81	53
54	PLUMBING FIXTURES ROOM 364	2004	8,800	220	20	220		220	54
55	CARPET DINING ROOM	2004	1,464	146	5	146		146	55
56									56
57	FIXED EQUIPMENT	1971	814,827		25			814,827	57
58	FIXED EQUIPMENT	1972	253,064		25			253,063	58
59	FIXED EQUIPMENT	1978	280,726		25			280,726	59
60	FIXED EQUIPMENT	1979	13,938		10			13,938	60
61	FIXED EQUIPMENT	1984	23,531		10			23,531	61
62	FIXED EQUIPMENT	1985	117,689	5,615	5,10,15,20	5,615		114,176	62
63	FIXED EQUIPMENT	1986	13,909		10,15			13,908	63
64	FIXED EQUIPMENT	1987	12,320	320	10,15,20	320		11,386	64
65	FIXED EQUIPMENT	1988	8,162	241	10,20	241		7,363	65
66	FIXED EQUIPMENT	1989	4,670	158	15	158		4,670	66
67	FIXED EQUIPMENT	1993	259,307	12,249	10,20	12,249		156,253	67
68	FIXED EQUIPMENT	1995	188,017	9,657	10,15,20	9,657		88,916	68
69	FIXED EQUIPMENT	1996	10,809	1,037	10,15	1,037		8,162	69
70	TOTAL (lines 4 thru 69)		$ 8,767,106	$ 238,562		$ 238,562	$	$ 4,792,670	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,767,106	$ 238,562		$ 238,562	$	$ 4,792,670	1
2	FIXED EQUIPMENT	1997	35,461	1,812	15,20	1,812		13,279	2
3	FIXED EQUIPMENT	1998	180,143	9,222	15,20	9,222		59,863	3
4	FIXED EQUIPMENT	1999	8,744	526	15,20	526		2,538	4
5	FIXED EQUIPMENT	2000	272,461	14,155	10,15,20,25	14,155		59,563	5
6									6
7	EXPANSION TANK BOILER	2001	2,780	185	15	185		649	7
8	FIRE ALARM NETWORKING	2001	2,041	102	20	102		357	8
9	CABLE WIRE 2 SOUTH COMPUTERS	2001	2,801	140	20	140		490	9
10	TOSHIBA VOICE MAIL SYSTEM	2001	5,156	516	10	516		1,805	10
11	SOUND SYSTEM FOR CHAPEL	2001	8,150	543	15	543		1,358	11
12	REPAIR FIRE SPRINKLER SYSTEM DEFECIENCIES	2001	4,715	189	25	189		472	12
13	REPLACED HOT WATER STORAGGE TANK	2001	3,150	158	20	158		394	13
14	NURSE CALL SYSTEM 3,4 NORTH	2001	11,826	591	20	591		1,478	14
15	5 TON ROOFTOP KITCHEN AIR CONDITIONER	2002	6,100	610	10	610		1,525	15
16	CHILLER SE WING	2002	26,230	1,749	15	1,749		4,372	16
17	90 SMOKE DETECTORS	2002	1,756	117	15	117		293	17
18	SPRINKLER SYSTEM REPAIR	2002	2,980	119	25	119		298	18
19	REPLACED AIR SEPARATOR	2002	2,810	187	15	187		468	19
20	REPLACED CENTER BOILER SECTION	2002	5,328	355	15	355		888	20
21	11 DOORS SPECIAL LOCKING UNITS	2002	24,522	1,635	15	1,635		2,452	21
22	NEW DOOR OPERATOR HW WEST ELEVATOR	2002	3,600	180	20	180		270	22
23	2 CENTER SECTION BOILER #3	2002	4,950	330	20	330		495	23
24	CONVECTION OVEN	2002	3,328	222	15	222		333	24
25	INTERMEDIATE SECTION BOILER	2003	5,300	353	15	353		530	25
26	HW ELEVATOR WEST	2003	44,290	2,215	20	2,215		3,322	26
27	4TH FLOOR SMOKE DETECTORS	2003	3,231	215	15	215		323	27
28	5 PANIC HARDWARE W/SWITCHES	2003	3,750	250	15	250		375	28
29	CABLE FOR ELEVATOR	2003	4,226	211	20	211		317	29
30	BOILER PLANT NEW PIPING & CONTROLS 90%	2003	16,754	1,117	15	1,117		1,117	30
31	BOILER REPAIR #2	2003	4,317	288	15	288		432	31
32	2,3,4 FLRS SMOKE DETECTORS DUCTS & PULL STATIONS	2003	6,707	224	15	224		224	32
33	NURSE CALL SYSTEM 3 WEST	2003	1,447	36	20	36		36	33
34	TOTAL (lines 1 thru 33)		$ 9,476,160	$ 277,114		$ 277,114	$	$ 4,952,986	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,476,160	$ 277,114		$ 277,114	$	$ 4,952,986	1
2	RELOCATE SMOKE DETECTORS	2003	6,179	206	15	206		206	2
3	3 DOOR ALARMS	2003	4,117	137	15	137		137	3
4	71 FIRE DAMPERS W/1HR RATINGS	2003	4,757	159	15	159		159	4
5	18 CEILING RADIATION FIRE DAMPERS	2004	3,840	128	15	128		128	5
6	REPLACE COPPER LINES TOSTORAGE TANK	2004	6,597	132	25	132		132	6
7	CRACKED SECTION #3 BOILER	2004	4,317	144	15	144		144	7
8	HANDRAIL OUTSIDE RAMP DINING ROOM	2004	14,780	493	15	493		493	8
9	BOILER	2004	5,000	167	15	167		167	9
10	HOT WATER RHEEM GBCP12 BOILER	2004	6,540	218	15	218		218	10
11	1 1/4" GAS CONTROL REGULATORS	2004	2,043	68	15	68		68	11
12	2,3,4 FLRS SMOKE DETECTORS DUCTS & PULL STATIONS	2004	1,946	65	15	65		65	12
13	CYLINDER KITCHEN ELEVATOR	2004	18,600	465	20	465		465	13
14	EXV VALVE EAST CHILLER	2004	1,526	51	15	51		51	14
15	BOILERS 1&2	2004	3,365	112	15	112		112	15
16									16
17	LAND IMPROVEMENTS	1975	2,807		25			2,807	17
18	LAND IMPROVEMENTS	1978	495		10			495	18
19	LAND IMPROVEMENTS	1979	6,425		10			6,425	19
20	LAND IMPROVEMENTS	1992	56,865		10			56,865	20
21	LAND IMPROVEMENTS	1995	18,601	1,550	12	1,550		14,596	21
22	LAND IMPROVEMENTS	1997	4,800	192	25	192		1,440	22
23	LAND IMPROVEMENTS	1999	44,219	3,685	12	3,685		20,268	23
24	LAND IMPROVEMENTS	2000	17,559	1,255	10-15-25	1,255		9,382	24
25	SHRUBS LANDSCAPING	2001	1,952	195	10	195		683	25
26	CONCRETE WORK	2003	8,404	560	15	560		840	26
27	SIDEWALK	2004	3,450	115	15	115		115	27
28									28
29									29
30	DEPRECIATION ON ASSETS DISPOSED OF			4,622		4,622			30
31									31
32	ROUNDING		(10)	(2)		(2)		(4)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,725,334	$ 291,831		$ 291,831	$	$ 5,069,443	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 523,194	$ 54,043	$ 54,043	$	5 TO 25	$ 266,190	71
72	Current Year Purchases	39,711	2,493	2,493		5-10-15	2,493	72
73	Fully Depreciated Assets	147,322					147,322	73
74								74
75	TOTALS	$ 710,227	$ 56,536	$ 56,536	$		$ 416,005	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINTENANCE	1997 3/4 TON GMC & PLOW	1997	$ 23,521	$	$	$	4,5	$ 23,521	76
77	RESIDENT TRANSPORT	2001 E-450 FORD BUS	2001	56,836	11,367	11,367		5	28,418	77
78	RESIDENT TRANSPORT	1994 FORD VAN	1995	36,216				4	36,216	78
79										79
80	TOTALS			$ 116,573	$ 11,367	$ 11,367	$		$ 88,155	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,740,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 359,734	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 359,734	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,573,603	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	VILLA INDEP UNITS 1988-89-91	$ 1,695,153	$ 42,737	$ 665,852	86
87	SUNSET APARTMENTS 2003	2,656,208	66,084	77,098	87
88					88
89					89
90					90
91	TOTALS	$ 4,351,361	$ 108,821	$ 742,950	91

G. Construction-in-Progress

	Description	Cost	
92	RENOVATION 1,2,4	$ 94,603	92
93			93
94			94
95		$ 94,603	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

COMMUNITY COLLEGE TRAINS AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 105,974	$		$ 105,974	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			60,722			60,722	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			182,526	3,391		185,917	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				72,481		72,481	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 349,222	$ 75,872		$ 425,094	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 387,608	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	699,205		3
4	Supply Inventory (priced at COST)	52,524		4
5	Short-Term Investments	286,276		5
6	Prepaid Insurance	47,641		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,473,254	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	49,194		12
13	Land	188,707		13
14	Buildings, at Historical Cost	9,725,334		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	826,800		16
17	Accumulated Depreciation (book methods)	(5,573,603)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,271,542		21
22	Other Long-Term Assets (spe CWIP	94,603		22
23	Other(specify): SEE ATTACHED	5,872,771		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,455,348	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,928,602	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 115,008	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	443,874		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SUNSET APARTMENTS	73,556		36
37	INS RESERVE HEALTH CLAIMS	101,261		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 733,699	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	N/P SUNSET APARTMENTS	3,118,306		43
44	REF FEES & DEFERRED REVENUE	96,367		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,214,673	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,948,372	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,980,230	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,928,602	$	48

***(See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,547,139	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,547,139	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	433,091	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 433,091	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,980,230	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,192,077	1
2	Discounts and Allowances for all Levels	(1,191,050)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,001,027	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,013	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,306	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,319	23
	D. Non-Operating Revenue		
24	Contributions	654,966	24
25	Interest and Other Investment Income***	196,984	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 851,950	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED	783,160	28
28a	CHANGE IN VALUE SPLIT INTEREST	235,403	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,018,563	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,878,859	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,974,613	31
32	Health Care	4,610,685	32
33	General Administration	1,692,502	33
	B. Capital Expense		
34	Ownership	603,422	34
	C. Ancillary Expense		
35	Special Cost Centers	72,481	35
36	Provider Participation Fee	92,446	36
	D. Other Expenses (specify):		
37	FUND DEVELOPMENT	54,028	37
38	SUNSET APARTMENTS	307,624	38
39	VILLA	37,967	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,445,768	40
41	**Income before Income Taxes (line 30 minus line 40)****	433,091	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 433,091	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,780	2,037	$ 51,762	$ 25.41	1
2	Assistant Director of Nursing	1,947	2,083	50,848	24.41	2
3	Registered Nurses	26,102	28,016	504,451	18.01	3
4	Licensed Practical Nurses	83,364	92,165	1,322,099	14.34	4
5	Nurse Aides & Orderlies	164,271	178,978	1,703,227	9.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,747	2,932	21,858	7.45	8
9	Activity Director	1,945	2,091	26,017	12.44	9
10	Activity Assistants	11,137	12,025	94,953	7.90	10
11	Social Service Workers	6,982	7,751	84,512	10.90	11
12	Dietician					12
13	Food Service Supervisor	1,899	2,091	35,941	17.19	13
14	Head Cook	1,768	2,091	29,462	14.09	14
15	Cook Helpers/Assistants	48,921	53,633	436,735	8.14	15
16	Dishwashers	5,730	6,494	58,478	9.00	16
17	Maintenance Workers	11,502	12,513	138,671	11.08	17
18	Housekeepers	27,338	29,975	233,011	7.77	18
19	Laundry	3,704	4,213	38,910	9.24	19
20	Administrator	1,780	2,091	81,623	39.04	20
21	Assistant Administrator					21
22	Other Administrative	5,601	6,324	114,017	18.03	22
23	Office Manager					23
24	Clerical	13,469	14,933	161,121	10.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,485	3,924	37,791	9.63	31
32	Other Health Care(specify)	10,686	11,822	117,913	9.97	32
33	Other(specify)	4,109	4,436	84,257	18.99	33
34	TOTAL (lines 1 - 33)	440,267	482,618	$ 5,427,657 *	$ 11.25	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,873	1-3	35
36	Medical Director		3,600	10-3	36
37	Medical Records Consultant		1,500	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,058	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,323	11-3	44
45	Social Service Consultant		2,323	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,677		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY KIRLIN	CEO/ADMIN	0	$ 81,623
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,623

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MEYER CAPEL LAW OFFICE	LEGAL	$ 2,270
SCHOLZ LOOS PALMER SIEBER	LEGAL	6,122
SCHOLZ LOOS PALMER SIEBER	LEGAL	8,814
TIMOTHY J WIEWEL CPA	AUDIT/ ACCTG	18,140
FROST & RUTTENBERG	MEDICARE ACCTG	5,210
KLINGER & ASSOCIATES	ENGINEERING	4,725
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,281

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 137,544
Unemployment Compensation Insurance	31,071
FICA Taxes	401,418
Employee Health Insurance	312,552
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
DISABILITY INSURANCE	5,780
PENSION	107,527
EMPLOYEE AWARDS	21,499
PHYSICALS	5,288
LESS FUND DEVELOPMENT	(5,300)
VACATION PERSONAL TIME	(72,713)
TOTAL (agree to Schedule V, line 22, col.8)	$ 944,666

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,311
Health Care Worker Background Check	1,000
(Indicate # of checks performed)	
LIFE SERVICES NETWORK DUES	9,191
OTHER DUES FEES	1,733
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,235

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,405
Seminar Expense	
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 8,405

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/03 Ending: 09/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/1/03 **Ending:** 09/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LIFE SERVICES NETWORK $9,191

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 60,038 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 92,466
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? YES Indicate the amount. $ 30,000

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: TIMOTHY J WIEWEL CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SUNSET HOME #0011643 10/01/03-9/30/04

XVIII STAFFING & SALARY COSTS

LINE 32 - OTHER	1 # OF HRS. ACTUALLY WORKED	2 # OF HRS. PAID AND ACCRUED	3 TOTAL SALARIES AND WAGES	4 AVERAGE HOURLY WAGE
NRS-SUPPLY COORDINATOR	2,027	2,197	19,371	8.82
NRS- TRANSPORTER	2,098	2,177	18,749	8.61
SOC SERV- DIRECTOR	869	972	14,930	15.36
NRS- CLERICAL	5,692	6,476	64,863	10.02
	10,686	11,822	117,913	
LINE 33 - OTHER				
HOUSEKEEPING & LAUNDRY DIRECTOR	1,905	2,092	28,003	13.39
MAINTENANCE DIRECTOR	1,951	2,091	44,651	21.35
ACTIVITIES- PASTORIAL CARE DIRECTOR	253	253	11,603	45.86
	4,109	4,436	84,257	

SUNSET HOME #0011643

BALANCE SHEET- SCH XV

SEPTEMBER 30, 2004

	OPERATING
LINE 23-OTHER	
VILLA BUILDING & EQUIPMENT NET OF DEPRECIATION (665,852)	1,029,301
SUNSET APARTMENTS LAND, BUILDING & EQUIPMENT NET OF DEPRECIATION (77,09	3,029,110
UNAMORTIZED BOND COSTS	102,991
ASSETS INTERNALLY (BOARD) DESIGNATED	382,161
ADDITIONAL LAND COSTS	395,311
LAND HELD FOR EXPANSION	933,897
	5,872,771

SUNSET HOME #0011643 SEPTEMBER 30, 2004

An interest income offset is not applicable at 9/30/04 because of the following reasons.

1) There has been a loss from operations for the last nineteen years. So no additional monies have been generated from operations for investment purposes.

2) The majority of investments are derived from contributions and endowments.

3) There have been various construction projects over the past several years which were financed through contributions and investment income earned on such monies and/or borrowings.

SUNSET HOME
#0011643
10/01/03-9/30/04

XVII INCOME STATEMENT LINE 28 OTHER REVENUE

GAIN ON SALE OR DISPOSITION OF ASSETS	(22,940)
VILLA INDEPENDENT LIVING	173,101
SUNSET APARTMENTS RENTAL FEES	618,240
MISCELLANEOUS INCOME	14,759
	783,160

XX GENERAL INFORMATION LINE 12

HOUSEKEEPING - LAUNDRY DIRECTOR 25% TO LAUNDRY 75% TO HOUSEKEEPING

SUNSET HOME #0011643 10/01/03-9/30/04

XIX SUPPORT SCHEDULE C. PROFESSIONAL SERVICES

		AMOUNT	INVOICES ATTACHED	
SCHOLZ LOOS PALMER SIEBERS	LEGAL	8,814	X	
KLINGNER & ASSOCIATES	ENGINEERING	4,274	X	CONSULTING CORRECT DEFICIENCIES FROM IDPA

SUNSET HOME #0011643
COST CENTER SCH V
10/01/03-9/30/04

	SALARY 1	SUPPLIES 2	OTHER 3	TOTAL 4	RECLASS 5	RECLASS TOTAL 6	ADJUST 7	ADJUSTED TOTAL 8
LINE 43-OTHER								
FUND DEVELOP.			54,028	54,028	5,300	59,328	(59,328)	0
SUNSET APARTMENTS			307,624	307,624	200,187	507,811	(507,811)	0
VILLA			37,967	37,967	42,737	80,704	(80,704)	0
	0	0	399,619	399,619	248,224	647,843	(647,843)	0